includes employer-based health care, where there couldn't be an exclusion for preexisting conditions. There are the existing government programs, Medicare, Medicaid. Part of the money, if we get the version we are looking for, would be to help States cover everybody for Medicaid.

Then the third thing, this would be new and would include a robust public option. The public option would be a program run by an agency in the government that would be not looking to generate a profit. In that case, would the public option that we have been talking about, would they be reaping a portion of those, what is that, $84 billion in profit? Would that be a cost measure within the public option, if we were able to achieve that?

Ms. EDWARDS of Maryland. Well, I think that what would happen is that the public option would be so competitive. Keep in mind that the CEO of the public option, the Secretary of Health and Human Services, doesn't make $9.8 million a year. It is a basic government salary, I don't know, about $175,000 or $185,000 a year to run all of Medicare. Our CEO is a government employee who doesn't make a ton of money, who is not reaping millions and millions of dollars in compensation.

This is only compensation. Maybe next time I will bring the bonus chart. That would require a lot more zeros.

But I think really there is so much overhead in the private insurance, and it is really sending costs up. All we want is a public option, and what the American people want is a public option, because something like 70-some percent of the American public actually support a public option, and what they want is something that competes with the private insurers.

After all, Mr. ELLISON, I am not really sure what the private insurers are afraid of, because if they believe in the free marketplace, put the public option in there, let it compete in the free marketplace, and I will tell you what, the competition will be on and costs will be down.

Mr. ELLISON. That is right. And lobbying expenditures, CEO compensation and profits will not be there.

We will have to yield back and be back the next time. This has been the Progressive Hour.

NOTICE OF CONTINUING EMERGENCY WITH RESPECT TO SOVEREIGNTY OF LEBANON—MESSAGE FROM THE PRESIDENT OF THE UNITED STATES (H. DOC. NO. 111–59)

The SPEAKER pro tempore laid before the House the following message from the President of the United States; which was read and, together with the accompanying papers, referred to the Committee on Foreign Affairs and ordered to be printed:

To the Congress of the United States:

Section 202(d) of the National Emergencies Act (50 U.S.C. 1622(d)) provides for the automatic termination of a national emergency unless, prior to the anniversary date of its declaration, the President publishes in the *Federal Register* and transmits to the Congress a notice stating that the emergency is to continue in effect beyond the anniversary date. In accordance with this provision, I have sent to the *Federal Register* for publication the enclosed notice stating that the national emergency declared with respect to the actions of certain persons to undermine the sovereignty of Lebanon or its democratic processes and institutions is to continue in effect beyond August 1, 2009.

In the past 6 months, the United States has used dialogue with the Syrian government to address concerns and identify areas of mutual interest, including support for Lebanese sovereignty. Despite some positive developments in the past year, including the establishment of diplomatic relations and an exchange of ambassadors between Lebanon and Syria, the actions of certain persons continue to contribute to political and economic instability in Lebanon and the region and constitute a continuing unusual and extraordinary threat to the national security and foreign policy of the United States. For these reasons, I have determined that it is necessary to continue the national emergency declared on August 1, 2007, to deal with that threat and the related measures adopted on that date to respond to the emergency.

BARACK OBAMA.

THE WHITE HOUSE, *July 30, 2009.*

DOCTORS HOUR

The SPEAKER pro tempore (Mr. KRATOVIL). Under the Speaker's announced policy of January 6, 2009, the gentleman from Louisiana (Mr. CASSIDY) is recognized for 60 minutes as the designee of the minority leader.

Mr. CASSIDY. Mr. Speaker, we are pleased to be here. We call this the Doctors Hour because there is a fair number of us on the Republican side who are physicians or in some way health care providers, optometrists, a practicing psychologist, or in some other way connected with the health care field. So we give our own perspective.

Now, my own bio, if you will, aside from being a physician, I have worked with the uninsured in my State of Louisiana for the last 20 years.

□ 2030

That's almost 90 percent of my practice, working with the uninsured in a public hospital. And so, when I speak of what we need to do to help the uninsured, it is purely flowing out of my life experience. I think that as the others come up I'll give them a chance to speak as to it what they're about. I'll start off with a couple of comments. I've learned in my 20 years of, whether private practice or public practice, that the only thing that lowers costs is if you make things patient-centric. If the government is in charge, or the insurance company or a bureaucracy run by anybody is in charge, it becomes something that doesn't work for the patient. The patient's separated from costs. They have a harder time accessing benefits. It just doesn't work.

On the other hand, if you put the patient in the middle, if you tell that woman, listen, you can go see the physician you wish to see and when you go in there there's minimal administrative hassle. And if you don't like that physician, you can go see another physician. It really works. The patient's satisfied, and typically, the patient/physician relationship is stronger. And key to getting good health care is having a strong patient/physician relationship.

Now, frankly, I think the only thing innovative that we've heard from the other side, although their plan kind of is changing on a day-by-day basis, is in one sense, the only thing about that plan which is radical is that it nationalizes health insurance. I was a little amused by my Democratic colleagues earlier who were saying, Oh, my gosh, Republicans are defending insurance companies. No, actually I think they're defending insurance companies. They like insurance companies so much they want to nationalize it and have a national insurance company.

Now I'm thinking, now we have an insurance company run by the private sector that, if it doesn't work, constituents call Congresswomen, Congressmen, we pass a law that changes that, changes that so that the private insurance company plays by better rules. Now, though, it's going to be both the referee and the player. Now the government will make the rules, but also compete. And as it does that, in some way, we're supposed to expect that the government-run insurance company is going to be kinder and gentler, more cost-effective, higher value product than is the private insurance company.

I think it's the triumph of hope over experience. We hope it will be better. We know Medicaid and Medicare don't work as we wish; in fact, they're going bankrupt, and their bankruptcy is what's driving this plan. And so we're going to believe that the third try is going to be the charm and that this time we get it right. Well, without going further, I'll yield to my fellow physician from Louisiana, JOHN FLEMING.

Mr. FLEMING. Well, I thank my friend and fellow colleague, both a physician and fellow Member of Congress, BILL CASSIDY, and also fellow Louisianan. And of course tonight we're going to be talking about a lot of different things relative to what is really the hottest topic maybe in a decade, health care reform, which both sides of the House are very interested in.

You know, you hear often from this side of the aisle that well, for heavens

sakes, we want health care reform. But you guys, on the other hand, Republicans, you want the status quo. Well, I can tell you personally, that I ran for Congress with the overarching intent of getting up here and participating in reform. What I want to bring forth first, before we get into some more details is, I think there's a litmus test as to how good a government-run system is, that proposed by the President and the Democrats. And so, the question is, a rhetorical question is, if it's so good, then shouldn't Congress be the first ones to sign up for it individually, for them and their families?

And, in fact, to see to that, I set forth House Resolution 615, which is supported by 66 Republicans, including our leadership on down, and all it says is that if a Member of Congress votes for a government-run health plan, a public option, if you will, then he or she is willing to forego the waiver, the carve out, the exception, if you will, that's built into their version, and join it immediately for themselves.

Mr. CASSIDY. Now, Congressman FLEMING, how many Democratic cosponsors do you have?

Mr. FLEMING. I'm sad to say to my friend, and I thank you for yielding back, that so far we have no Democrats, goose egg, zero Democrats.

Mr. CASSIDY. Now, reclaiming my time, because we heard a presentation prior to this that, by golly, this is the best thing since sliced bread; this is the plan that's going to fix everything, and why wouldn't you be on it. So I'm kind of asking you, Dr. FLEMING, why wouldn't they want to be on it.

Mr. FLEMING. Well, I think that is the $100,000, or shall I say, $1.6 trillion question, because apparently they're not so enthralled with it that they would like to be in it themselves. And in fact, I put it to the test by actually putting it on my Web site and asking people if they would like their congressman to support it, that they would actually reach out. We have 150,000 Americans who signed the petitions, and the number is growing drastically every day.

And so I would say that, as we go through this debate, that we simply ask our constituents out there to hold us in Congress accountable by contacting your Congressperson or Senator or even the President and say, Mr. President, Mr. or Ms. Congressperson, Mr. or Ms. Senator, will you go to fleming.house.gov and sign up, cosponsor or whatever, House Resolution 615, that simply says that if you're willing to vote for it you're willing to join it.

Mr. CASSIDY. Now, reclaiming my time, and I appreciate that because, again, what we've heard before is that this plan does not put government between the patient and their physician. And yet, I would have to think, if that weren't the case, why wouldn't anyone agree to your bill? I think your amendment was proposed in our committee, and it was defeated on party line votes. So I think Dr. ROE, from Tennessee, may have some thoughts as to what would come between the patient and the physician. I keep emphasizing that because if something's patient-centered, we know the closer it is to the patient, the more likely it works. So let's ask Dr. ROE, a physician from Tennessee, what might come between the patient and the physician. Dr. ROE.

Mr. ROE of Tennessee. Thank you, Dr. CASSIDY. This evening members of the GOP Doctors Caucus want to talk to you about health care solutions. All of us are physicians who ran for Congress, in part, because we saw challenges in our health care system and wanted to be part of a debate on how to improve it. This is my first term. And when I first arrived I was energized by the opportunity to reform how the health insurance industry works and help make health care more affordable, which are probably the two biggest complaints about today's system.

I quickly realized, however, that the House Democratic majority had a radically different vision of how health care should be delivered. Rather than allowing patients and doctors to make health care decisions, House Democrats' plan is to have Washington bureaucrats decide what is and is not allowed based on its cost effectiveness.

Mr. CASSIDY. Dr. ROE, can I reclaim my time?

Mr. ROE of Tennessee. Yes.

Mr. CASSIDY. Can you show me up there where there is a Washington bureaucrat on that chart? Where might there be a bureaucrat on that chart? Show me where the patient is and show me where a bureaucrat is.

Mr. ROE of Tennessee. Well, the patient, Dr. CASSIDY, is here and here. These are the patients over here. And this person right here, whoever this may be, will be one of the most powerful people in the U.S. This will be a health care commissioner who will decide what is adequate and not adequate insurance coverage. This bureaucrat right here will be very much in those health care decisions.

Mr. CASSIDY. So unlike the Republican plans, which are patient-centric, what you're telling me is this is kind of a top-down, let's figure it out from Washington and lay it on the rest of the country.

Mr. ROE of Tennessee. That's correct. And the solution should come the other way, from the grassroots up. Absolutely. In addition, they, the bureaucrats would create a system so complex that today's system would look like a walk in the park. And then to put the framework in place for government-run health care, the plan called for creation of a government-run insurance company, the so-called public option, which would, over time, bleed out the private insurance industry, because it would be mandated to pay rates less than the cost of care.

In my district, the First District of Tennessee, they call this socialized medicine, and they've sent me here with a very clear message to deliver. Please defeat this bill. People in my district want health care reform. They really, really do. I talk with people all the time who hate insurance companies, and in my time as a doctor, as you all have, I've often spent more time on the phone getting an insurance company to approve a procedure than I did actually doing the procedure. I also talk with people all the time who believe that reform is possible and that results in them getting the same care for less money. And I tell them it's possible, if we focus on rooting out waste in the system.

But even with this desire for reform, people in my district are clear that increasing Washington bureaucrats' roles in health care is not the direction they want our health care system moving in.

Mr. CASSIDY. Dr. ROE, can I reclaim my time?

Mr. ROE of Tennessee. Yes.

Mr. CASSIDY. Of course we don't want this to be a partisan issue. Now frankly, as far as I know, Republicans have not been invited into the discussion. And there are actually some things in that Democratic plan, those thousand pages, that I think are very good. But there's other things, and I think they kind of general concept top-down. But it's not just us.

David Brooks is a columnist for The New York Times. You see him on TV, a very thoughtful man. I have a quote here. The health care system is as big as the entire British economy. There's no way something that big and complex and dynamic can be run out of Washington. We have to set up a dynamic system, not trying to establish a set of rules to be imposed by fiat. Now, I think what you're telling me is that this is a big, complex plan run out of Washington, and not the dynamic system, but rather a set of rules, and whoever that really powerful person is in that purple box, that person will be establishing the rules by fiat. Is that a fair statement?

Mr. ROE of Tennessee. That is correct. And one of the things, Dr. CASSIDY, I think that's very important, that I've heard, and I've got some other comments in a minute. But I think it's very important when you hear about the cost of this health care plan. This plan's somewhere around $1 trillion over 10 years, which doesn't start paying any money out in the plan till 2013. So really, it's $1 trillion over 5½ years. Now, let me just explain why that is an extremely low number.

Mr. CASSIDY. Hang on. Hold that thought. Let me give one more David Brooks quote and call on our colleague, Dr. FLEMING okay? Another David Brooks quote talking about the CBO report, speaking about how much it would cost. This is devastating. The plan was sold as a way to bend the cost curve to reduce the rate of health care cost growth. Instead, the cost of the plan to the Federal budget would rise by 8 percent a year, and there wouldn't be anything close to offsetting revenues to pay for it.

Now, Dr. FLEMING, can you sustain a health care system which has out of control inflation, if you will?

Mr. FLEMING. Well, my answer to the gentleman is that I would look to the experience of other health care systems in other countries. If you look at Medicare and Medicaid, we've not been able to do that. Medicare is running out of money. We don't have a solution to that. The States all across the country are having tremendous difficulty figuring out how they're going to pay for Medicaid budgets, their part of it. And then if you look at the U.K., you look at Canada, countries around the world who have these systems, none of them have been able to claim that they can control costs. They're inflation rates are 10 percent or more.

Mr. CASSIDY. Reclaiming my time, part of this plan is to increase Medicaid eligibility, i.e., put more people on to Medicaid. Yet what we've just heard is that Medicaid is bankrupting States, or causing them to raise taxes.

Mr. FLEMING. Absolutely.

Mr. CASSIDY. So going back to my question, if you cannot control costs, can you sustain a health care system?

Mr. FLEMING. In my opinion, no, because, again, if you can't do it for a smaller system, how can you enlarge the system and somehow make it mysteriously work, particularly when there are no models? Massachusetts, Tennessee, TennCare, and so on and so forth, no one has an example of a government-run system that works.

Mr. ROE of Tennessee. Will the gentleman yield?

Mr. CASSIDY. I will yield.

Mr. ROE of Tennessee. Let me just tell you the folks out there, and we're going spend about the last half of this hour talking about the positive solutions and what we do agree on. But when I first came to D.C. and I heard of this public option I said, I've heard this before. And in Tennessee, in the early nineties we had managed care that was going to control the cost. We got a waiver from HHS and formed a program called TennCare, where we had about 8 different managed care organizations competing for your business. Now we have one.

In the 1993–1994 year, the State of Tennessee spent combined Federal, State revenue, $2.5 billion. Eleven years later, 10 to 11 years later, that had gone to over $8.5 billion. It had tripled and took up almost a third of the State's entire budget. We were complaining about 17 percent now. This took up almost a third and almost every new dollar that the State took in.

Mr. CASSIDY. Reclaiming my time, let me just praise the motivations of the people in Tennessee. They clearly cared about the uninsured, as our Democratic colleagues, are. But it was a flawed model and couldn't be sustained, and we know that those patients were now uninsured again, probably worse off than before the experiment.

Mr. ROE of Tennessee. Well, actually, what happened, just to go over that a little bit, over that period of time, in Tennessee, it was a noble goal to cover as many of our people in our State as we could. But over a short period of time, 45 percent of the people who got on TennCare had private health insurance.

□ 2045

Our Governor is a Democrat, Governor Bredesen. As you all know and as everyone in this Hall knows, in a single-payer system, the way costs are controlled is by rationing care. Well, what we did in Tennessee was, about 200,000 people were removed from the rolls, and what did a significant number of those people do? They went back on their private health insurance.

There is another thing that, I think, you have to ask yourself. By tripling the amount of money you spend on health care, what kind of outcomes will there be? Ultimately, that is what you're really interested in.

What we ended up with in Tennessee was the highest per capita prescription drug use in the Nation, and number two, we were 47th in health outcomes.

I yield back.

Mr. CASSIDY. Dr. BOOZMAN, I would like your opinions on this. You're an optometrist from Arkansas.

Mr. BOOZMAN. Well, thank you very much.

You know, it's interesting. I think we bring up a good subject. When I'm home, one of the things that I hear very, very much from the seniors is, we have a Medicare system that's functioning pretty well. Yet, when you look at it in 2017, it has all kinds of fiscal problems. Their question to me is: Why aren't you fixing the government program you have now before you expand it greatly to millions of people? You guys can correct me or can add to this: I've heard anywhere from 10 percent of the Medicare bill that we pay is just waste and fraud. Why aren't we addressing that?

Mr. CASSIDY. Reclaiming my time, 10 percent in Medicare, a generally accepted figure, is in waste and fraud. So we hear from our colleagues across the aisle that Medicare has lower overhead costs. If you include in that the 10 percent, which is a common way to define ''overhead,'' actually, that 3 percent becomes at least 13 percent. A fair statement. I think an economist would say, if your overhead is so meager that you can't watch out for fraud and abuse, then you need to lump the cost of the fraud and abuse into your overhead.

Mr. BOOZMAN. I agree. As a guy from Arkansas, I just know that there's a heck of a lot of fraud and waste in the system. Rather than expand it like we're talking about doing now, why not fix that first? We hear about the pizza parlors that are charging for dialysis and, you know, things like that.

So, again, I would say that we need to get our act together there and reform the Medicare system that we've got.

I know I'm in a situation now. It's not uncommon at all for me to have people my age call and say, My mom has moved to town, and I can't find a Medicare provider because the fees are so low for physicians that people have started either limiting the slots that they use for the Medicare practice or they've simply discontinued the practice in their clinics.

Mr. CASSIDY. Thank you.

Dr. BROUN, you've joined us. May we have your thoughts on this, please?

Mr. BROUN of Georgia. Well, I thank y'all. I appreciate y'all doing this tonight, and I appreciate your yielding me some time. I think the American people need to know several things about this, and y'all have brought up some very good points.

The CBO says that this ObamaCare plan is not going to save money. It says that, in 10 years, we're still going to have almost 20 million people in this country who won't have health insurance. They need to understand that illegal aliens are going to be given free health insurance by the Federal Government.

Now, last night I was watching C–SPAN, and one of our Democratic colleagues was just railing on about how illegal aliens will not get ObamaCare.

The reality is, in the Energy and Commerce Committee, just today, this morning, one of my Georgian colleagues introduced an amendment to the bill that basically said that you have to look at people's citizenships and confirm whether they're U.S. citizens or not. That was defeated almost on a party-line vote. All of the Republicans voted for the amendment. Most all of the Democrats did not. I think there were one or two who voted with my Republican colleague from Georgia. The amendment was to just affirm that somebody was here legally to get free health insurance. We saw that with SCHIP.

When I first came up here during the last Congress, we had numerous debates about SCHIP, and we had fights over giving State Child Health Insurance Programs to illegal aliens. Our Democratic colleagues absolutely fought and won the fight on this issue. People who come are going to be asked a question, Are you an illegal alien? When they say, No, I am not an illegal alien, then they're not going to do anything to check the legality or the truth of that statement. So it's a self-determination by the applicants as to whether they're legal or not. If they say they're not illegal, then they're going to be given free health insurance under this government plan.

The other thing that, I think, is extremely important for the American people to understand is that this plan is going to cost American workers a tremendous salary decrease. Plus, it is going to put a lot of American workers out of work. In fact, it has been projected that over 100 million people are

going to be forced off of their private insurance. Also, as Dr. ROE was just talking about, it happened in the TennCare.

So I've heard a figure of 114 million people who have private insurance today who are going to be forced off their private insurance plans onto this so-called ''public option.'' Well, how does that work?

Well, I have businesses in my own district in northeast Georgia that have told me, businessmen and -women, that they'd rather pay the 8 percent tax, the pay-or-play tax. It would cost them less to pay the extra tax and then put their folks, whose insurance they're paying for today, over on the government plan, the socialized medicine/government plan.

I saw a video today of BARNEY FRANK, who was questioned about the government option. He said in this video, in his own words, that this is the way to get everybody in this country on a single-payer system. So, as to the claim that our Democratic colleagues put forth, which is, if you have private insurance you can keep it but if you don't then we'll give you a public option, is not factual.

They're setting up the game such, as BARNEY FRANK just very blatantly said in this video today—and I think it's on YouTube, and you can go look at it—that this government option is the means to get everybody on one single-payer system provided by the Federal Government, socialized medicine.

Mr. CASSIDY. If I can reclaim my time, let's give credit where credit is due, because the advocates for a public option plan—I'm not an advocate of one, though—will point out that there's a decrease in administrative costs.

So, Dr. ROE, will you look up at that chart once more—or maybe you will, Dr. BOOZMAN—and give us a sense of what will be the administrative costs, do you imagine, with this publicly run health insurance plan.

Mr. ROE of Tennessee. Well, here, Dr. CASSIDY—and then I'll turn it over to JOHN—if you'll look at this—and it's so complicated that it's almost comical—the problem with it is that this is how your health care is going to be administered.

I do want to say for every physician in this room and in this Congress, both Democrat and Republican, and this is truly from the bottom of my heart, it has been a privilege to be a physician and to be able to provide care for people and to administer to them. I believe, and I think every Republican and Democrat believes, that health care decisions should be made between a family, a patient and the doctor.

Now, having said that, if you take a look at having to go through this, you're going to have a Benefits Advisory Committee—and I don't mean this funny, but when the Lord got tired, a committee built a moose, anything that ugly. Basically, this here is going to be deciding what's adequate here as administered by this down here. You'll have the Bureau of Health Information. We'll have comparative effectiveness outcomes.

I want to tell you the other thing. The people who really need to be fearful are senior citizens when you start looking at getting rid of Medicare Advantage and when you start talking about carving as much as $500 billion out. I don't think our seniors right now feel like too much is being spent if you'd talk to them and see what their supplementals cost. Well, do you know what that means when you spend less money? You're going to provide less care, and there's no plan in the world that can provide more and more care for a lot less money.

Mr. BROUN of Georgia. Dr. ROE, would you yield for 1 minute?

While you're talking about the seniors, I think the seniors need to understand, too, about this ObamaCare plan and understand that it mandates that those seniors have counseling, I think it is, every 5 years. They have to go get counseling every 5 years about dying. This is a government bureaucracy. I'm not sure where it is in your chart there because it's so hard to figure out what all this bureaucracy is that's being placed between the patient and the doctor.

Yet one of those bureaucracies is going to every 5 years tell people over 65 years of age, basically, that they have a responsibility to look at how they're going to die and how they're not going to cost the American taxpayer money, is basically what they're going to tell them.

Mr. CASSIDY. I thank you for offering that.

Reclaiming my time, Dr. BOOZMAN, JOHN, when you look at that, some patients aren't as sophisticated as others. Let's face it, some folks don't have the same education. Maybe they've had to struggle a little bit to get through life. Imagine if a patient had a problem with that and didn't have a counselor coming to them, as Dr. BROUN mentions, but, by golly, they just have a doctor they don't like, don't get along with, and they want to complain to someone. Where would they complain?

Mr. BOOZMAN. I think that's a real problem.

As was mentioned, one of the things that we see in this type of plan is rationing for seniors. Are they going to be able to get the knees? the hips? In my case, being very familiar with cataract surgery, is somebody going to allow them to have that as they get older and allow them to ease their pain and lead a quality of life?

You know, we're talking about getting preventative care and all this. Well, you do a great job, and you live, and you get up in years, and then we're going to take away the ability for you to go ahead and continue that quality of life.

Mr. FLEMING. Will the gentleman yield?

May I add that the bill, itself, is scored at over $400 billion to be taken out of the current Medicare program. That's over $400 billion to be taken out of the current Medicare program. So that's actually in their bill itself. So I don't see how they can claim that the elderly will get more care. They're only going to get less care.

Mr. BOOZMAN. I agree with the gentleman. If he would yield?

Mr. FLEMING. Yes.

Mr. BOOZMAN. There are so many questions that are unanswered when you look at this chart. If you get denied, you know, who do you appeal to? Is there any appeal?

Mr. CASSIDY. Reclaiming my time, I know there's supposed to be an ombudsman. In the 1,000-page bill, I've found one page that spoke of an ombudsman whom you would call up if you had a complaint.

I guess the point I'm making about administration—I read an article in the McKinsey Quarterly. They said there are three things you absolutely have to do if you're going to control costs. You've got to decrease administrative costs. I look at that and it just gives me a migraine.

Mr. BOOZMAN. If the gentleman will yield, the first thing you've got to do is have some tort reform, and you guys can, you know, very well spell out how you practice defensive medicine when people come in with headaches and things like that, and there's one thing that's not on that chart. There's nothing about nuisance lawsuits, which are driving up the costs of medicine and which make it such that we have counties in Arkansas, where I'm from, that don't have any OB because the guys can't afford the malpractice insurance.

Mr. CASSIDY. If I can reclaim my time, Dr. BROUN, as far as you know with the bill, how does the bill address tort reform?

Mr. BROUN of Georgia. It does not.

Mr. CASSIDY. I'm sorry?

Mr. BROUN of Georgia. It does not address tort reform.

Mr. CASSIDY. We just heard from our colleague from Arkansas that that's a critical thing to do.

Mr. BROUN of Georgia. Well, I was just fixing to ask Dr. BOOZMAN to yield so I could tell him a story.

Two days ago, I talked to the administrator of one of the major hospitals; it's a regional hospital within my congressional district in northeast Georgia. He was telling me just that day that one of the CAT scan techs, a lady, was up in his office, asking for more help in their CAT scan unit at night.

He asked her, Why do you need so much in the way of help there? She said, Because of all the massive amounts of CAT scans that we're running up here through the night which are ordered through the emergency room.

They did 10 CAT scans in one night on patients who'd come in. The administrator's question was, How many of those CAT scans were positive? Zero. Not the first one.

I've worked full time for part of my career as a director of emergency medicine at Baptist Hospital in Georgia.

I've been involved in emergency medicine throughout my medical career, sometimes part time, sometimes no time, when I was just doing family medicine, and other times full time.

Particularly doctors in the emergency room are having to do CAT scans on people who come in with all sorts of aches and pains when they really don't need to do those, but they're having to do those CAT scans and MRIs just because somebody might come back later on and sue them for missing a diagnosis.

Mr. CASSIDY. Now, Dr. BROUN, if I could reclaim my time, earlier, Dr. ROE had suggested—we spent the first half in kind of a critique of what our folks, our colleagues across the aisle, have put forward; but we've set aside our second half to kind of talk about what works. This is kind of a nice segue because I think, one, we know that lowering administrative costs will help, and we know that malpractice reform can also address some of these issues.

I'll go back to the central theme, which has to be that any effective reform has to put the patient in the middle; and when you put the patient in the middle, you've got to give them transparent costs so they know what they're buying before they go in there, and you need to encourage them to make the lifestyle changes because, ultimately, a patient, she or he, is ultimately responsible for his own health.

□ 2100

I know that, Dr. Fleming, in your business—because you're not only a physician, a congressman, husband, and a father, but you're also a small business man—could you relate your experience with health savings accounts? Perhaps define them for us and say how it worked in your small business.

Mr. FLEMING. Absolutely. I will tell you, approximately 5 years ago, and this is when health savings accounts really——

Mr. CASSIDY. Will you define what that is, please?

Mr. FLEMING. Yes. A health savings account is really very simple, where either the subscriber—the employee—or the employer, as in our case, puts part of the subscription costs into a savings account.

Mr. CASSIDY. Reclaiming my time, you put a portion of that health premium into a bank account of sorts that the patient/employee then controls?

Mr. FLEMING. Not only does he control, but it is nontaxed, and he can use it to buy prescription drugs, to pay the deductible or whatever.

And we were up against a situation where, like many small businesses, our premiums were going up 9, 10 percent, sometimes 15 percent per year, and we were pulling our hair out trying to figure out what else we could do. And this idea of health savings accounts came out, and we said, Well, let's try this. I had some reluctance from my employees, but we increased the deductible, and the extra amount that we would have paid for the increase in subscription costs, we put it into a health savings account for each and every one of them.

The results were dramatic. The costs flatlined. They did not go up. And since then, they've never gone up more than 3 percent a year. It's empowered the employee, the patient, the family, to buy medications at will.

And it was very interesting. I had one employee who was complaining as we implemented. She said, Well, gee, I spend $200 a month for inhalers, and how is this going to help me out because I'm going to be spending a lot of time. I said, Well, let me suggest that you stop smoking, and with the money that you save by not having to use inhalers, you will have plenty of money left over. She took me up on it, and now she doesn't need them.

Mr. CASSIDY. Reclaiming my time, could she have used her HSA to buy the medication to help her get off of cigarettes?

Mr. FLEMING. Absolutely.

Mr. CASSIDY. Now, I like that because it puts the patient, the empowered patient in the middle so that she's making the best decisions not only for her wallet, but also for her health and, by the way, for her job because you are able to keep your costs down and keep her employed.

Fair statement?

Mr. FLEMING. Absolutely.

Mr. CASSIDY. Dr. Roe, I think also you've had experience with putting patients in the middle with these health insurance plans. Can you relate that, please.

Mr. ROE of Tennessee. In our own practice, we had traditional health insurance, as most people did, 80/20 cost. As Dr. Fleming was saying, costs were continuing to go up, and about 3 years ago we introduced this plan for the physicians. There are 11 of us in the group, and all of us decided to go on this plan. And 2 years ago, we have a group that has 294 employees that elected to get their health insurance through our plan at the office: 294, 70 providers, doctors, and extenders. Eighty-four percent of those, of our people, our employees in our office, chose this plan because it put them in control of the dollars.

Let me explain to you how that is. If you believe in wellness and prevention—and the way our plan worked was you had a $5,000 deductible. That scares everybody to death. But our group put $4,200 per person in there.

Mr. CASSIDY. Reclaiming my time, you had a savings account for the patient, $4,200, that you put in there to help pay that high deductible?

Mr. ROE of Tennessee. Yes.

Mr. CASSIDY. But now it's coming out of their pocket if they buy the expensive medicine as opposed to the insurance company.

Mr. ROE of Tennessee. And guess what the empowered person does? At the end of the year, they've been healthy, they've taken care of themselves, they keep that money. But let's say they have an illness or a wreck or something happens to them. Anything above that deductible is paid 100 percent. So you have catastrophic coverage, but you're in control of the first dollars. And by doing that, again, I think as you pointed out in our Education and Labor meeting, that particular type of insurance protection is 30 percent lower than standard.

Mr. CASSIDY. Reclaiming my time, for a similar-size family, similar benefits, with a health savings account costs are 30 percent lower relative to traditional insurance.

Now, we've talked about and quoted David Brooks talking about the Congressional Budget Office comment that the plans being presented to us do not bend the curve; they elevate the cost curve. And yet here is something which has been proven—it's not a hope, but it's experience—to lower costs by 30 percent.

Mr. ROE of Tennessee. That is correct. And when you empower consumers, as I've said, how many of us have driven across four lanes of interstate to buy gas 3 cents a gallon cheaper? Americans are great shoppers, and they will look after it, as opposed to—when they're spending their own money, they are very careful with it, as opposed to the government up here which is not careful with their money.

Mr. CASSIDY. Reclaiming my time, John, if I can ask you, those patients we talked about earlier, and maybe they haven't had the same educational opportunity, the same economic opportunity, but nonetheless, if gas were cheaper 3 cents a gallon on the other side of the interstate, do you think they would go over four lanes to get it?

Mr. BOOZMAN. Very much so. I was looking on the chart, and it's not up there. But other things, the associated health plans, where if you're a florist, a small business man and you've got your little store and you go in and try to negotiate with the insurance company, you don't have a very strong negotiating position. But if we would allow them to go in with others, thousands of florists, then they could negotiate as a group and get a much better rate like a major corporation.

Mr. CASSIDY. May I add, that is part of some of the Republican alternatives that are being proposed. Allow those small business women and men to band together perhaps to purchase one of these empowering HSAs.

Mr. FLEMING. Why is it that they can't do that now?

Mr. BOOZMAN. In doing that, then you have to go across State lines. Also, different States have different mandates as far as what they—you have to offer in particular States.

So we could do that at the Federal level and get rid of all of that stuff and not go across the State line.

Mr. BROUN of Georgia. If you would yield just a moment, I would like to point out something. The commerce

clause of the Constitution—I'm an original constitutionist, as many people in this House know. In fact, I carry a copy in my pocket. I carry it all the time, even when I'm home doing all sorts of things. I don't take it with me when I go in the shower, but almost.

But the commerce clause under its original intent was supposed to do just exactly what you're talking about, Dr. Boozman, is allow interstate commerce across State lines. And what we've done is we've perverted the Constitution in many ways. And this is one way that commerce clause has been perverted tremendously.

The commerce clause was supposed to make sure that there would not be a lockbox of goods and services at the State line. It was supposed to facilitate interstate commerce, not to control interstate commerce but to facilitate it.

And so we have perverted the Constitution markedly. And this is one good point that the Republicans are pointing out today about trying to give patients the ability to buy the insurance directly from an insurance company across State lines or have these pools with their alumni association. I went to the University of Georgia. We could have a University of Georgia Alumni Association pool. I went to the Medical College at Georgia for medical school. We could have an MCG pool. I'm a Rotarian. We could have a Rotary pool. We could have these huge pools that would help stop some of these problems with portability. It would help solve some of the problems that we have.

Mr. CASSIDY. Reclaiming my time, you always give me these nice bridges to segue into. Some of the Republican alternatives—and you're actually addressing all of those very nicely. And if you're a member of Rotary, you can do that. Now, I like that.

So can I call on my good friend, Dr. Fleming, if he can initiate some of the discussion of just what the Republican Study Commission is putting forth, not necessarily what Mr. RYAN has put forth or others, but even this step plan.

Mr. FLEMING. You often hear rhetoric from the Democrat side of the aisle that we are the party of the status quo, the party of no, we don't want reform. That is the main thing I ran on to come to Congress. I want health care reform. But I want commonsense reform, not nonsense reform, and that's what the Democrats are offering us.

The first completed bill—there are different versions of bills on the Republican side, but the first completed bill that's actually been dropped because we've been working behind the scenes for weeks and months to get it perfect, is the Empowering Patients First Act, which I am a proud original cosponsor, and here are some basic parts of it.

No. 1, access to coverage for all Americans. It covers preexisting conditions, and that is the big problem that everybody is talking about here tonight, risk pools.

Mr. CASSIDY. Reclaiming my time, so if you will, what's being said by our colleagues across the aisle to misrepresent our positions, we absolutely favor insurance reform to allow folks with preexisting conditions to get coverage, correct? That's what you just said, correct?

Mr. FLEMING. Yes.

Mr. CASSIDY. So next time someone gets up to the podium and says we don't believe that, that is incorrect; am I correct?

Mr. FLEMING. You are correct.

Mr. CASSIDY. The fact is that is misleading. And that is one thing I like in their plan and I like in our plan.

I yield back.

Mr. FLEMING. It also protects employer-sponsored insurance. But on the other hand, it actually gives ownership of the plans to the individual, and also the individual can buy it outside of their employer.

Mr. CASSIDY. Reclaiming my time, the anecdotes that you gave and Dr. ROE gave regarding the empowered patients by giving them these health savings accounts or something such as that, we empower patients. That's in our plan. It's not the government bureaucracy between our friends up there; rather, it is empowering patients.

Mr. FLEMING. This does not exist. This matrix that you see there with Dr. BOOZMAN, that does not exist in this plan.

Mr. BROUN of Georgia. Dr. CASSIDY if you will yield for a second, to draw a contrast here, too, is this the plan that you were just talking about, Mr. FLEMING. A patient or an employee can choose whether they want to purchase their plan through their employer or not; is that correct?

Mr. FLEMING. That is correct.

Mr. BROUN of Georgia. Well, in the Democratic plan, they're going to be forced to buy the employer-provided health care insurance or they're going to be taxed at a 2 percent increased tax rate over what they're being taxed today. So their taxes are going to go up by 2 percent. They're going to be forced into that employer-provided health care plan that's going to be dictated—if you'll hold just a second, I want to make one very strong point here that people need to understand.

That employer-provided health care plan is going to be dictated by the health care czar panel. It is established on this menagerie of colors and blocks and things.

Mr. FLEMING. Yes.

Mr. BROUN of Georgia. So the employers won't have a choice anymore about the plan that they offer their employees, and the employee won't have a choice either. And both of them are going to pay a penalty if they don't do what the Federal Government mandates or dictates to them; is that correct?

Mr. FLEMING. That is correct. And also, the government will have to actually certify all health plans. It will be a one-size-fits-all.

Mr. ROE of Tennessee. Would you yield?

Mr. FLEMING. Yes.

Mr. ROE of Tennessee. The Empowering Patients First Act that you just talked about does not contain, as Dr. BROUN just described, these mandates, these taxes.

Mr. CASSIDY. So, Dr. ROE, may I interrupt for a second?

A clear contrast between our plan, if you will, or one of our plans and their plan, aside from their increased administrative costs, aside from their top heavy, aside from ours being lower administrative costs and patient-centered, you're saying that one of the plans being presented to us has the mandates but the Republican plan does not.

Mr. ROE of Tennessee. That's correct.

Mr. BROUN of Georgia. That's the point I was trying to bring up, too, doctors, if I could speak directly to the American citizens, as I cannot due to the rules here.

But if the American citizens understand, the Democratic plan is going to dictate their plan to them. It's all going to be run by government dictation or dictum from Washington, D.C., and this health care czar; whereas, the Republican plan gives the patient and the employer the choice of what they want to do. And that's why I wanted to try to draw that contrast as you were talking.

I yield back.

□ 2115

Mr. FLEMING. Let me finish up because there are only a couple more points left. It also reins in out-of-control costs. This goes back to malpractice reform. This has malpractice reform. The government-run plan has not a word about malpractice reform. And finally, this is budget-neutral. That plan over on this side of the aisle is $1 trillion to $1.6 trillion, depending on which year span you are talking about, of course, with the CBO telling us that the costs curve up, not curve down, over time, despite what our President has told us. This one starts out with no cost, no net cost. There are savings built into it.

Mr. CASSIDY. If I may reclaim my time, it's important that the people watching realize that that is not just Republicans saying this. Again, I'm going to quote. The Congressional Budget Office, as we know, has spoken about how costly this bill would be.

From nytimes.com, I, again, quote David Brooks:

''The theory of the Democratic bills seems to be that 98 percent of Americans can party on, with the latest and costliest health care imaginable, no matter how ineffective, and the top 2 percent will pay for it all.'' He goes on to say, ''If you don't control the rate of health care inflation, even the rich won't be able to pay for the cost increases.''

So it's others, not in this Chamber, commenting on the cost of that program and, indeed, commenting on the Congressional Budget Office comments.

Mr. FLEMING. And really, just to get down to the basics, if the patients, if the public, the consumer doesn't have skin in the game, there's no money to be saved in this. If it's all on the providers and all on the government, you will never see costs controlled.

Let me add one other thing before I yield. We were talking a moment ago about the fact that illegal immigrants will be covered under this plan, 10 million or more.

Mr. BROUN of Georgia. Not our plan but the Democratic plan.

Mr. FLEMING. I'm sorry. The Democratic plan provides coverage for illegal immigrants. The Republican plan does not. The Republican plan presumes that we will deal with immigration problems through an immigration reform process. But getting to my final point here is, the other thing that the government-run plan, the Democrat plan, provides for is taxpayer-funded abortions. Not only taxpayer-funded abortions, but an actual mandate, the requirement for convenience. There will have to be convenience centers throughout the country so that young women will not only have access but will have easy access, all at the taxpayers' expense. None of that, of course, is provided for in the Republican plan.

Mr. ROE of Tennessee. If the gentleman will yield, I have a letter that I received from a constituent which was given to me this past week; and I think it's worth passing on. It says:

''Dear Dr. Roe,

''My wife Missy and I are aware of the struggle you face on Capitol Hill over government-run health care. We wish to offer you our personal story of how the current system saved our son, Robby, to use as you see fit to put a human face on our side of this issue. Robby suffers from unbearable pain that began when he had a severe infection he contracted September 2007. It began one Saturday. He went to bed feeling a little off and woke up the next morning with a severe ear ache. Within 5 hours, his eardrum ruptured. In spite of several courses of antibiotics, this infection continued to spread into every cavity of Robby's head, and it began to attack his nervous system and his brain. The pain was torturous. Robby was admitted to the Knoxville Children's Hospital for over a week. The infection finally stopped with I.V. antibiotics, but the damage had been done. Robby lost the ability to walk. He also developed a motor vocal tick associated with constant shooting pain in his head. We researched Robby's symptoms and found doctors at Vanderbilt Children's Hospital in Nashville and Children's Hospital of Philadelphia where Robby was treated by the head of pediatric neurology. We were able to visit these doctors and receive treatment for our son only because our private health insurance gives us the flexibility to do so. In the last 18 months, Robby's been hospitalized six times, including most of this March. Pain medicine, including morphine, PCA, hydrocodone and Demerol gave no relief. He had to be sedated for over a week until the pain subsided. There is still no definitive diagnosis. In spite of this, Robby has had multiple exploratory procedures, MRI, CT, et cetera, and tried nearly 20 medications. We finally found the medicine that helped 4 months ago. This has eased his symptoms significantly. He is doing much better but is still not able to return to school. Throughout this ordeal, the medical system has been helpful, responsive, timely and accessible at all levels. We were always around to be a part of the decision-making process in our son's care from medicines and procedures to which doctors and hospitals treated him. We recently learned of another boy in our area who was about Robby's age that suffered from similar symptoms. He died. We believe competent, fast, flexible care that would be impossible under a government-controlled system saved Robby from this fate. Missy and I lived under a government health care system in the Army. I grew up in an Army family. I remember sitting for hours in the military emergency room with a broken arm.''

He goes on, ''and we had no recourse. You can't sue the government. We are not wealthy people. We make well below the median income and have had to pay thousands of dollars out of our own pocket to get Robby where he is now. It has been a struggle, but we would gladly pay any amount to ensure the timely care and freedom of choice needed to treat our son. It is true that under a government-controlled system we wouldn't have had these medical expenses. We believe they would have been funeral expenses. Please feel free to use our story. We would be glad to testify or do anything else you feel would be beneficial.''

This is Rob and Missy Mathis from Newport, Tennessee.

Mr. CASSIDY. If I may reclaim my time, one, it's a tremendous testament to the faith of that family, their love for their son and to those fine physicians at Vanderbilt. I think all of us share the hope to have high-quality health care affordable, accessible to all Americans. Our concern is that the solutions being brought upon us are going to not only not achieve that but interfere with that relationship, and it's not just folks who are conservatives.

I have an editorial in my local paper by Susan Estrich. You will recall that Susan Estrich was chief of staff for Walter Mondale—I think I have this right—when he ran for President. I don't agree with her, but I respect her thoughts. She's a bright woman. She wrote Don't Risk Your Health Care.

She begins:

The President is ''not familiar'' with the bill. No one can explain how it will work yet, as Senator BEN CARDIN told a contentious town meeting. There are various plans, and negotiations are still in the early stages. But whatever it is, we should be for it.

She goes on to say, ''Am I missing something?''

Then she describes the relationship that she and her family have with their physician. They are not sure. She wants to be reassured and has seen nothing that reassures her yet that that relationship will be preserved. So it isn't just folks in this arena. It's folks across the country.

Dr. BOOZMAN, what are your thoughts?

Mr. BOOZMAN. Well, I would just say that all of us—and in hearing the letter, all of us have seen patients in our practices that we knew as we prescribed the treatment that they couldn't afford, hardworking people that just didn't have the ability to afford that. So we definitely need reform, and we've talked about that. We need portability. We need more competition, things like that. What we don't need, though, is to try to get this thing done in 2 or 3 weeks.

I was on this school board for 7 years. If we were trying to change the curriculum of the high school class, we'd spend more than 2 or 3 weeks doing due diligence. But to try to do that in a period of 2 or 3 weeks makes no sense at all.

The other thing I would say is that we don't need government-run health care. We don't need to go down the path towards Great Britain and Canada. And something I'd like for you guys to comment on—because you have treated them and things—tell us about the results of cancer and things like that in the Canadian and Great Britain systems compared to the United States. I guess my concern is, in an effort to fix our pretty good system—you know, it's working pretty good—that we actually destroy the system to fix the part that's broken.

Mr. CASSIDY. Reclaiming my time, I would say that it works for 85 percent of the people; but we would favor the reforms that would ease the insecurity that if you get sick, you lose your insurance or it's priced out. So we favor the reform that deals with preexisting conditions. At the same time, we don't want to ruin it for the 85 percent.

I yield to my friend.

Mr. BROUN of Georgia. I thank you, Dr. CASSIDY, for yielding. I just wanted to give you a couple of quick stories, one that goes along with Dr. ROE's story. I have a surgical colleague that I was talking to who told me about getting a phone call from a government bureaucrat about a Medicare patient that he had in the hospital. The doctor got the call from the Medicare bureaucrat in Atlanta who said, Doctor, we have reviewed such-and-such a patient that I understand you have in the hospital. Yes. We have reviewed it. She does not meet criteria to be hospitalized, and we want you to discharge her today.

The doctor said, Well, have you seen my patient?

No.

Are you a doctor?

No.

Are you a nurse?

No.

So you're just a government bureaucrat, is that correct?

Well, I work for CMS.

He said, You've not seen my patient at all?

No.

But you have determined that this patient should not be in the hospital, and you want me to discharge her?

That's correct.

He said, This patient is extremely ill; and if I discharge her, she is very likely to die. I'm not going to discharge her.

The government bureaucrat said, Doctor, you don't understand. We've determined that if you don't discharge this patient today, we're going to fine you $2,000 a day.

So the doctor went and talked to the patient's family and the patient. What were they to do? Well, he discharged her. She died that night at home.

Mr. CASSIDY. Reclaiming my time just for a second, CMS is the agency that governs Medicaid and Medicare, the Federal program.

Mr. BROUN of Georgia. This was a Medicare bureaucrat.

That's the kind of care that the Democratic plan is going to not only give us more of, but it's going to take it down to lower age groups besides those 65 years of age and older. It's government intrusion into the health care system that has run up the cost tremendously. CBO has already said that the Democratic plan is going to cost more money. It's not going to bring the costs down.

Y'all were talking about the cost curve going up. What that means to the people who don't understand, that means it's going to be more costly for the health care system under the Democratic plan than what we have today.

Mr. CASSIDY. If I may reclaim my time, we're almost out. I just want to wrap that in with a comment that Dr. FLEMING said about how the best system is one in which the patient is involved. I think you said ''skin in the game.'' The McKinsey Quarterly talks about transparent pricing for value-conscious people. Again, quoting from David Brooks, the New York Times columnist, a very thoughtful man: ''I'd say that there have to be cost-conscious consumers within a closely regulated market. Unless you get proper incentives for both providers and consumers, I doubt you're going to go very far. In the current plans,'' meaning those across the aisle, ''all the emphasis is on the providers.''

Mr. BROUN of Georgia. Dr. CASSIDY, if you don't mind yielding for another moment, let me tell you about something that happened in my medical practice down in rural southwest Georgia. Congress passed CLIA, the Clinical Laboratory Improvement Amendments. I had a fully automated lab in my office where I would do blood sugars, blood counts and things like that. If a patient came in to see me with a red sore throat, running a fever, white patches on the throat, coughing, runny nose, I would do a complete blood count to see if they had a bacterial infection and thus needed antibiotics to treat it. Or if they had a viral infection, they could have the same clinical picture but didn't need the cost or the exposure to the antibiotics. CLIA shut my lab down and every doctor's lab in this country down. Prior to CLIA, I charged $12 for that CBC. It took 5 minutes to do with quality control. After CLIA, I had to send patients across the way to the hospital, it took 2 to 3 hours to get the test and cost $75 for one test. It goes from $12 to $75, and 5 minutes to 3 hours. Now this is how government intrusion into health care markedly drives up the cost.

Mr. CASSIDY. If I may reclaim my time, I think you are involved in what is called as a concierge practice or a patient-centered practice where the patient will prepay you, say, $50 a month; and if you don't satisfy that patient, she goes to see another doctor.

Do I recall that correctly?

Mr. BROUN of Georgia. Well, not exactly. In fact, I have discharged patients at the time I see them. I don't have that concierge practice where I am prepaid. But actually, I charge less. My practice was a full-time house call practice. I was not working in an office.

Mr. CASSIDY. If you would yield back, because I just want to mention that one thing. There are some physicians, a lot of them on the west coast, that have a practice that is so patient-centered, it works beautifully. In that practice, the patient pays $50 to $100 a month and gets all the primary and preventive services cared for. If the patient doesn't like it, they find another doctor the next month. It's like Target or Wal-Mart. If my wife doesn't like the sale at Target, she goes over to Wal-Mart; and if she doesn't like the service at Wal-Mart, she will go back to Target. The fact is, is that the physician, knowing that those folks can go, is going to be more patient-sensitive.

Mr. BROUN of Georgia. And the Republican plan allows patients to do that, where the Democratic plan does not.

Mr. CASSIDY. Thank you all very much.

□ 2130

ENERGY IN AMERICA

The SPEAKER pro tempore. Under the Speaker's announced policy of January 6, 2009, the gentleman from Ohio (Mr. BOCCIERI) is recognized for 60 minutes.

Mr. BOCCIERI. Mr. Speaker, this snuck up on me with respect to the timing. My colleagues on the other side of the aisle finished much earlier; they didn't have as much to say as we are tonight about clean energy.

I am joined by my colleague from New York, Congressman MCMAHON, who I will recognize here very shortly to talk about one of the pillar issues, one of the seminal issues that we're going to address in this Congress, in this body.

We've already taken action with respect to moving an energy policy forward that puts our country first. And truly, this is about making America stronger, making our country stronger by investing in America.

Now, I know some may think that that's a novel idea, but this is not about Democrats or Republicans. This is not about their ideas versus our ideas. This is about Americans and American innovation, and it's something that I feel so passionately about.

Today we're going to talk about this energy bill that passed through the Congress here, through the House of Representatives. We're going to talk about what has made this such an important issue in the coming weeks that we hope that the Senate will take action as soon as possible.

Before I get too deep into my long speech here, I would like to recognize the gentleman from New York to say a few opening remarks with respect to energy and what we have to offer here in the House of Representatives.

Mr. MCMAHON.

Mr. MCMAHON. Thank you, Congressman BOCCIERI. And thank you for your leadership on this issue.

Mr. Chairman and Mr. BOCCIERI, it is a privilege and an honor to stand here in the House of Representatives tonight and talk about this important issue. And I bring to it a perspective I think that is very important in this debate. You see, I come from New York City. I grew up in Staten Island, New York, and I now have the privilege and honor of representing Staten Island and Brooklyn, New York, here in the House of Representatives.

For the last few weeks and months, I've been very disappointed at the rhetoric that I've heard in this Chamber, and beyond, from those on the Republican side of the aisle. They, quite frankly, have had their heads in the sand. They, quite frankly, have been tied up in the rhetoric of partisan politics. And I say that as a New Yorker, as someone who suffered and saw firsthand what happens when this country doesn't deal methodically and honestly with energy policy.

You see, September 11, a date that we all know too, too well, in my opinion—and in the opinion of the people of New York and people around the world—occurred because our country has not dealt honestly and fairly with energy policy. Oh, I know it was the act of terrorists, there's no question; men bent on hate, men bent on Islamic fundamentalism to bring down this Nation. But our country has been caught